STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 86682-001**
v

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 14th day of January 2008
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On December 11, 2007, XXXXX, on behalf of her minor son XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on December 18, 2007.

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on December 28, 2007.

The Petitioner is enrolled for group health coverage through Michigan Educational Special Services Association (MESSA). The issue in this external review can be decided by a contractual analysis. The contract here is MESSA's *Choices II Group Insurance for School Employees* (the certificate). BCBSM underwrites this coverage and MESSA administers it. The Commissioner

reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner underwent surgery on March 7, XXXX, to excise benign lesions on his neck and scalp. The surgery was done by XXXXX, a nonparticipating provider (i.e., he has not signed an agreement with BCBSM to accept its approved amount for the service as payment in full). BCBSM paid $300.00 of the $990.00 charged by the surgeon. This left the Petitioner to pay the balance of $690.00.

The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on November 28, 2007, and issued a final adverse determination the same day.

III
ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's surgery on March 7, XXXX?

IV
ANALYSIS

Petitioner's Argument

The surgery to remove moles from the Petitioner's head and neck was necessary because the moles were growing and changing. According to the Petitioner's mother, the Petitioner's pediatrician and dermatologist both said XXXXX was the only surgeon they would recommend for such delicate surgery.

Because XXXXX was recommended by his doctors, the Petitioner is requesting that BCBSM pay the full amount charged for his surgery. The Petitioner believes he had no other choice but to use XXXXX.

BCBSM's Argument

BCBSM says that the certificate does not guarantee that charges will be paid in full. Its approved amounts for physician services are based on the lesser of the doctor's charge or BCBSM's maximum payment level. Since XXXXX did not participate with BCBSM, he is not required to accept BCBSM's approved amount as payment in full.

The amounts charged by the surgeon and the amounts paid by BCBSM for the March 7, 2007 surgery are set forth in this table:

Procedure Code	Amount Charged by Surgeon	BCBSM's Maximum Payment Amount	BCBSM's Approved Amount	Amount Paid by BCBSM	Petitioner's Balance
11442	$ 520.00	$ 209.00	$ 209.00	$209.00	$ 311.00
11441	$ 470.00	$ 182.00	$ 91.00	$ 91.00[1]	$ 379.00
Totals	$ 990.00			$ 300.00	$ 690.00

In determining the maximum payment level for each service, BCBSM says it applies a Resource Based Relative Value Scale (RBRVS), a nationally recognized reimbursement structure developed by and for physicians. The RBRVS reflects the resources required to perform each service. BCBSM regularly reviews the ranking of procedures to address the effects of changing technology, training, and medical practice. BCBSM says there is nothing in the certificate that requires it to pay any additional amount even if the care was provided for a life-threatening condition or even if there were no participating provider to provide the care.

BCBSM believes that it has paid the proper amount for the Petitioner's care by a nonparticipating provider and is not required to pay any additional amount.

Commissioner's Review

The certificate does not guarantee that charges will be paid in full. BCBSM pays an "approved amount" for physician and other professional services. The approved amount is defined

1. BCBSM pays 50% of its approved amount for the less costly procedure when multiple surgeries are performed on the same day by the same physician through different incisions.

in the certificate as the "lower of the billed charge or [BCBSM's] maximum payment level for the covered service." Participating providers agree to accept the approved amount as payment in full for their services. Nonparticipating providers have no agreement with BCBSM to accept the approved amount as payment in full and may bill for the balance of the charges.

BCBSM paid for the Petitioner's surgery of March 7, XXXX, based on its full approved amount for the most costly procedure and one-half of its approved amount for the less costly procedure. This practice is based on a national standard recognized by BCBSM and is included in the terms of the certificate. Because the Petitioner was referred to XXXXX by a panel provider, BCBSM did not apply the sanctions that would otherwise apply to services from a nonpanel provider ($250.00 deductible and 20% copayment).

It is unfortunate that the Petitioner did not use a participating or panel surgeon. Nevertheless, there is nothing in the terms and conditions of the Petitioner's certificate that requires BCBSM to pay more than its approved amount to a nonparticipating provider, regardless of the circumstance.

The Commissioner finds that BCBSM has paid the Petitioner's claims correctly according to the terms of the certificate and is not required to pay more for the Petitioner's care.

V
ORDER

BCBSM's final adverse determination of November 28, 2007, is upheld.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.